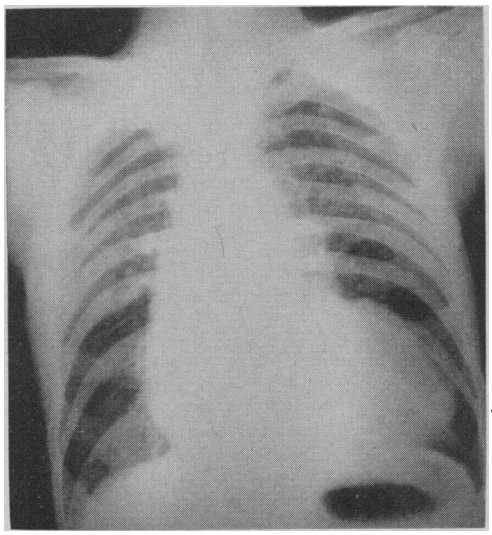

Fig. 3.—Radiographic appearance of chest showing large ventricular aneurysm.

In the case discussed here, it is most likely that the ventricular aneurysm developed on account of lack of rest and care. Briefly, the pathological changes in an acute infarction are leukocytosis, necrosis and softening of muscle fibre. This is followed by organization of scar tissue and finally fibrosis. If we bear this in mind, we should hesitate to advocate early ambulation. We can expect the possibility of ventricular aneurysm if we allow patients who have had uncomplicated attacks of acute infarction to be up and about before four to six weeks.

To minimize the risk of ventricular aneurysm, patients with acute infarction must be treated with the utmost care. Prolonged rest, both mental and physical, is of prime importance in avoiding such a major complication. Relief of pain, adequate oxygen administration, and attention to nutrition and sedation are also necessary in treatment.

SUMMARY

A case of ventricular aneurysm of unusually large size is presented, in which early ambulation was a likely cause. Radiographic examination is in most cases the only definite means of diagnosis. Adequate rest, both mental and physical, is one of the chief methods of treating acute infarction and avoiding cardiac aneurysm.

I wish to thank Dr. I. D. Maxwell for the photographs used in this paper.

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CHRONIC ULCERATIVE COLITIS: RECOVERY AFTER LEUKOTOMY*

MILO TYNDEL, M.D., Ph.D. and
WILLIAM FORSTER, M.B., B.S., D.P.M.,
Brandon, Man.

ALTHOUGH the specific etiology of chronic ulcerative colitis has not yet been established, and the pathologist considers most cases as "idiopathic",[1] many writers now believe it to be a psychosomatic disorder.[2] In fact, there is an extensive literature dealing with the basic precipitating factors of acute or insidious onset and relapse.[3-5]

Most writers agree with regard to the narcissistic organization of the personality in this disease. As to precipitating factors, Murray[6] stressed the importance of conflicts centring around marital relationships, sexual relations, pregnancy and abortion. Sullivan and Chandler[7] found in every case that the patient had been involved in a situation to which it was difficult for him to adjust and to which he had responded with tension and anxiety. Daniels[8, 9] noted the presence of a self-destructive, suicidal component, often after the illness or death of a near relative, particularly the mother, but he also noted that loss of money and financial worry act as precipitating factors.

After various forms of bereavement the patient, unable to face the situation alone, experiences intensification of his need for dependency. This is a threat to him, since it results in a tendency to regress to childhood behaviour patterns. Consequently the feelings of dependency are denied and are covered up by the opposite—feelings of aggression. When regression to childhood behaviour patterns occurs, the latter are coloured by phantasies of extreme violence, and by asocial behaviour characterized by aggressiveness and overcritical, demanding, or "spoiled child" attitudes.[10]

In Sperling's opinion,[11] ulcerative colitis represents the "somatic dramatization" of melancholia.

Dealing with the physiological mechanism, Portis[12] considers that certain emotional conflicts affect the colon through the vegetative centres and parasympathetic pathways. This is followed by surface digestion of the mucosa, preparing the way for bacterial invasion. On the

*From the Hospital for Mental Diseases, Brandon.

basis of the experimental work of Karl Meyer and his associates,[13, 14] Prudden *et al.* believe that lysozyme, a mucolytic enzyme, increases through parasympathetic stimulation and deprives the mucosa of its protective mucin so that it becomes more vulnerable to the tryptic enzyme present in the intestinal content. The initial localization of the ulceration is always in that part of the large bowel supplied by the sacropelvic portion of the parasympathetic. The locus of the signs in early cases is thus significant, and confirms the psychiatric observation that the psychological stimuli concerned pertain to the act of excretion.

It is probable that local somatic factors may determine whether the regressive evasion of a life situation producing conflict evokes in one patient entirely psychological symptoms (obsessive-compulsive pictures or paranoid delusions) and in another an organic bowel disturbance.

Finally, Alexander,[4] in a thorough evaluation of the emotional factors associated with excretion from an early age, shows that patients having ulcerative colitis closely resemble those suffering from other forms of diarrhœa. Defæcation in infancy is associated with attitudes of "giving" and "accomplishing". Regression to this anal level is extremely common both in neurotics and in patients who tend towards projection and psychotic episodes. Alexander assumes that some specific local somatic factors may be responsible for anal regression producing ulceration of the bowl in some patients.

The problems and effects of prefrontal leukotomy will not be discussed here. There is already an extensive literature on the subject.[15, 16] The most important effect of the operation is relief of tension and anxiety in chronic psychoses and obsessional neuroses.

The patient, a 35-year-old white married woman, was admitted to the Brandon Hospital for Mental Diseases in catatonic stupor. There was no family history of psychoses or bowel disorders. Her birth had been normal; she had had the usual childhood diseases, and underwent tonsillectomy at 4 years and appendectomy at 7, pleurisy at 18, and removal of ovarian cyst at 26. She attended school from 7 to 15, did well, and adjusted to other children and her teachers. Menarche occurred at 14, for which she was partially prepared but nevertheless was upset. She had considerable dysmenorrhœa. After leaving school she worked as waitress and sales clerk, changing jobs either because she did not care for the work or because of illness. She was liable to depression. She smoked and drank considerably until about two years before admission, when she stopped drinking because she thought the beer gave her diarrhœa. She was promiscuous from the age of 19, and promiscuity continued after marriage. Her first marriage ended in divorce at 26; her second husband left her when she was 33. She had never had strong sexual feelings and experienced orgasm only twice in her life. She became pregnant at 19.

At 22 she suffered concussion in a car accident, and following this had many complaints, particularly of headache and "nervous stomach". About two years before admission she began to have diarrhœa and almost continuous abdominal pain, and passed bright red blood and mucus in her stools, as well as tarry stools. She had the urge to defæcate almost constantly, and never felt she was able to empty the rectum completely. She lost appetite and weight and felt ill with increasing weakness. About a year before admission she began to have "seizures"; she would feel hot, everything would appear red, and she would fall unconscious for 10 to 15 minutes. She never injured herself, bit her tongue, twitched, or voided, and she never had the seizures when alone. They stopped "when the weather got hot", but from then on she believed she was dead, that her stomach had killed her and that she had no pulse. She had the delusions that her rectum and vagina were covered with skin, that she had no feeling, and that there were sacks of fæcal masses inside her. She kept to her bed, neglected herself, was hostile and negativistic. She would sit in the corner, nude, exploring her rectum with her fingers.

On admission and during her hospital stay she presented the clinical picture of catatonic schizophrenia. She masturbated and continually tried to empty her rectum with her fingers. Physically, she had no serious abnormalities apart from wasting, a moderate normochromic anæmia, and some tenderness on palpation along the large intestine. There was an occasional leukocytosis, eosinophilia and increased sedimentation rate. Her fæces were covered with blood and mucus, and at times pus. When these were absent, occult blood was a constant finding. X-ray studies showed no malignancy. Skull radiographs and EEG were negative.

Repeated physical treatments (electroshock, insulin coma, and electrostimulation with the Reiter apparatus) were followed by only slight and transient improvement. After prefrontal leukotomy, however, both her psychosis and her physical condition improved rapidly, including the symptoms and signs of ulcerative colitis. After an uneventful postoperative course she was discharged and has remained well for a year.

COMMENT

An emotionally unstable personality with hypochondriasis and chronic diarrhœa developed the picture of catatonic schizophrenia during difficult and apparently unbearable life situations. It is probable that the same psychological stress caused the concomitant ulcerative colitis in the presence of chronic mechanical irritation of the rectum by manipulation with the fingers. Prefrontal leukotomy had a considerable effect in relieving tension, leading to marked improvement in the catatonic symptoms and delusions, as well as in the somatic manifestations in the large bowel. Lessening of the emotional tension also contributed to the latter improvement by cutting out the digital irritation of the rectum.

It would seem that somatic conditions, probably due to emotional stress, should also be

taken into account when the question of psychosurgery arises in chronic psychiatric disorders.

SUMMARY

A case of chronic ulcerative colitis in a catatonic schizophrenic is presented. Both conditions cleared up after prefrontal leukotomy. In the discussion of the mechanisms of chronic ulcerative colitis the belief is stressed that: (a) it is due to emotional stress which may also lead to psychotic manifestations; (b) in the presence of local somatic changes in the intestine, the picture of chronic ulcerative colitis may develop.

Our thanks are due to Dr. Stuart Schultz, Medical Superintendent, Brandon Hospital for Mental Diseases, for permission to publish this case.

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PRIMARY TUMOURS OF RIB

In a Hunterian Lecture, 50 personal and some further cases of rib tumours are discussed. Chondromas and chondrosarcomas are commonest and originate in the centre of the bone, expanding it. They are usually of long standing and are seen when pain develops, usually in young adults. Local recurrence after excision does not necessarily indicate malignant change. Drastic surgical removal is justifiable unless metastases are obviously present.

The lesions that mimic cartilaginous tumours—fibrous dysplasia, lipoid granuloma, myeloma, osteoclastoma and chronic inflammation — are differentiated. Secondary tumours, especially endothelioma of the pleura, are sometimes difficult, or metastases from an undiagnosed primary in the kidney, adrenal, bronchus or thyroid may occur. Radiographs are necessary but their interpretation should be viewed with suspicion.—N. R. Barrett: *Brit. J. Surg.*, 43: 113, 1955.

Special Article

TEACHING OF PREVENTIVE MEDICINE IN CANADA

G. R. F. ELLIOT, M.D., C.M., D.P.H.,*
Vancouver, B.C.

RESOLUTION ON PUBLIC HEALTH TEACHING IN CANADA[1]

"WITHIN RECENT YEARS the practice of medicine has changed. Old problems have been replaced by others, as yet, unsolved. No longer does the doctor contend unavailingly with numbers of communicable diseases. Rather, he is faced with complex problems of an aging population, accidents and industrial disease, mental illness and many others. These problems force the doctor to adjust the focus of his attention and necessitate changes in the content of courses offered the undergraduate medical student. Nowhere have the changes been more apparent than in the areas of public health and preventive medicine. There is little need to stress that the preventive aspects of clinical medicine never required more emphasis, while the values of restorative methods only begin to be recognized.

"Much of value would accrue to all medical schools in the development of better courses if detailed information were available on existing undergraduate courses in public health and preventive medicine offered in Canadian medical schools. The details should embrace staffing, teaching methods and facilities, timetables, course content, research activities and the integration and relationship with clinical subjects including the extent of combined teaching with clinical departments. Such information would stimulate the medical schools to integrate instruction in these areas into the total educational programme and, thereby, achieve better preparation of the future practitioners of clinical medicine.

"To this end, it was recommended that the Canadian Medical Association undertake a survey and report on undergraduate instruction in Public Health and Preventive Medicine as conducted in the medical schools of Canada."

The above is a resolution passed by the Public Health Committee of the Canadian Medical Association in 1955. This Public Health Committee had a membership representing all ten divisions of the Canadian Medical Association and included public health physicians, general practitioners, hospital administrators, pædiatricians, psychiatrists, obstetricians and gynæcologists; the committee supported this resolution unanimously. The resolution has been tabled, since a committee of the Association of Canadian Medical Colleges under Dean Chester Stewart of Dalhousie University has this matter under study. It is felt that Dean Stewart's report should receive close study by the incoming Public Health Committee of the Canadian Medical Association in order to confirm or refute the above resolution. This has been recommended by the

*Assistant Provincial Health Officer, Province of British Columbia, and Assistant Professor, Department of Public Health, University of British Columbia.